Health Care Costs & Spending: Latest State Strategies

Presentation for the
Iowa Legislative Commission on Affordable Health Care Plans for Small Businesses and Families

September 19, 2007

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Director, Health Program - Denver
National Conference of State Legislatures

NCSL

rev. 9/17/07

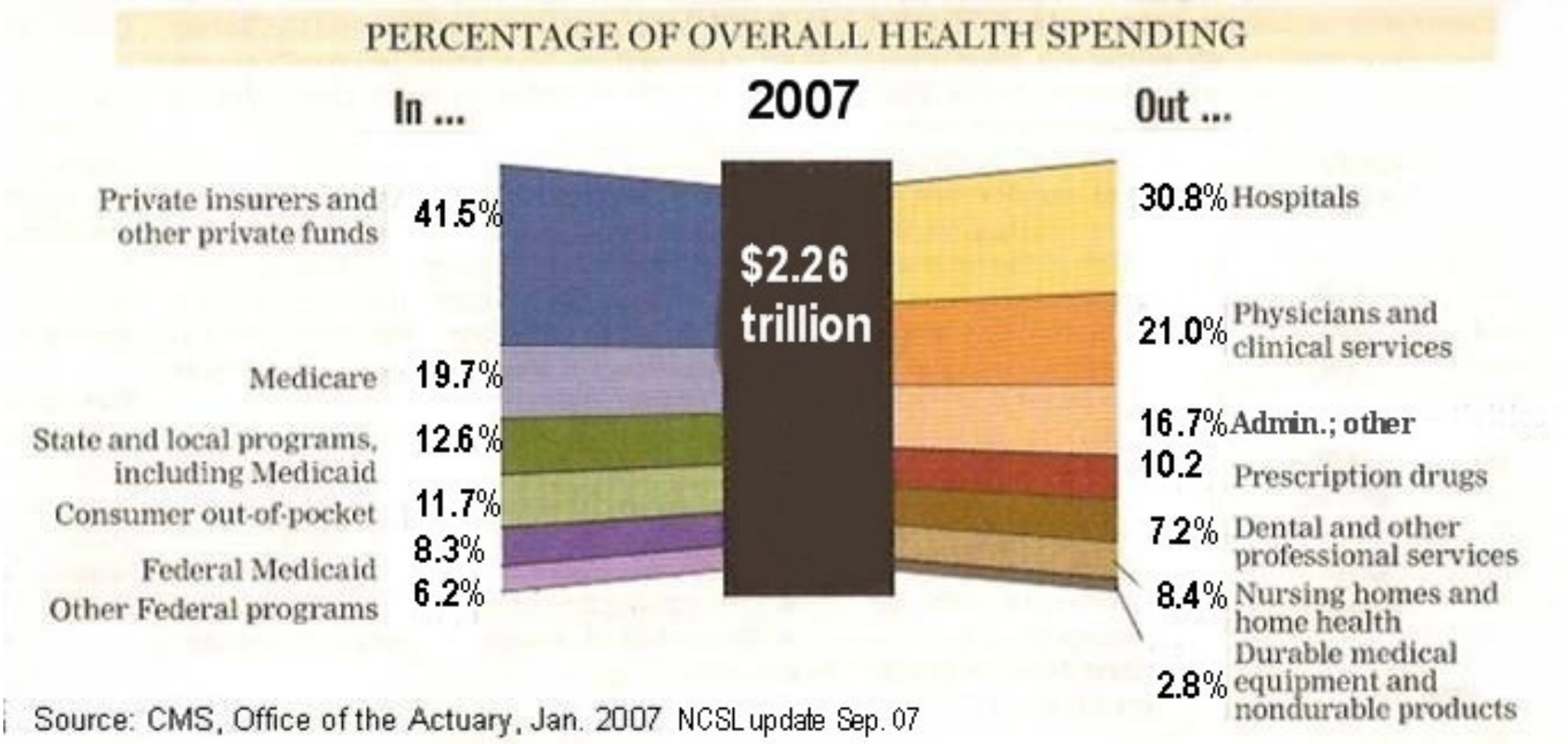
Overview

- Increasing health costs: where & why
- Insurance: costs versus coverage
  - Traditional conflicting strategies; now merging
- Finances: current realities + latest ideas
- Checklists: states' mix and match solutions
  - Cost containment and expanded coverage combined in reform legislation
  - Quality, disclosure and wellness in the mix
  - A multi-year process in most states

The human side of health policy

- Accurate, up-to-date data is important, but...
- State Legislators care more about the human impact –
  - Will your constituents get the medical care they need?
  - Will they be able to afford it as a family?
  - The impact of one unnecessary death.
  - The cancer patient dropped from insurance.
  - The family that loses their home.
- Many state reform actions, from mandates to tax credits look to practical help for people.
- State solutions often combine "market-based" and "government regulation"

National Health Expenditures with Services and Supplies by Category



Figures are projections. "Other" includes administration, the net cost of insurance and government public health activities; Other "personal health care" adds another 2.9 to the "Out" side%

Long term cost drivers: 2 economists' views:

- Medical technology
  - New research, knowledge
    - Radiation, imaging, chemotherapy
    - Pharmaceuticals, biotech
- Prices
- Unhealthy behavior
- Aging population
- More generous coverage
- Inefficiency
- Inappropriate use; overuse; under use
- End-of-Life interventions
- Liability

-based in part on Dr. Michael Chernew, Harvard Medical School, and Brent James, MD, Institute for HealthCare Delivery Research, at NCSL, Aug. 7, 2007

- No clear agreement among economists

Annual Change in Total Health Benefit Cost

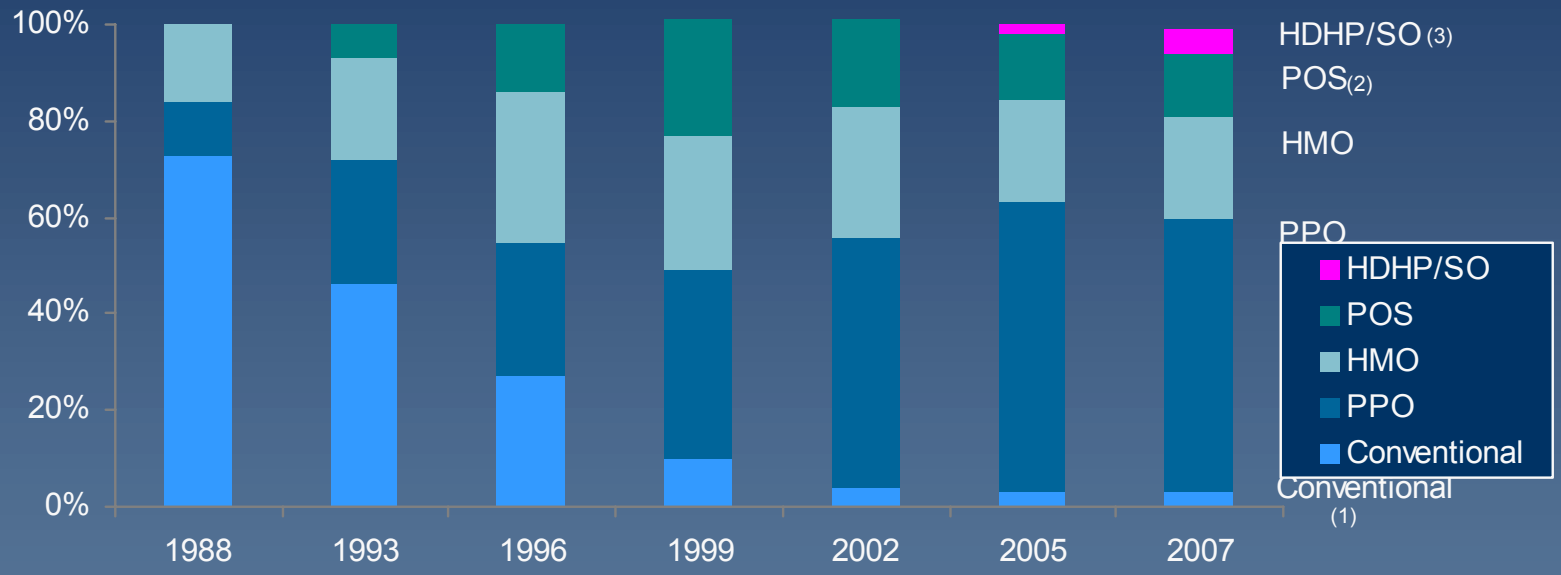
1990-2007

Cost growth levels off at 6.1%

Note: Benefit costs includes all types of coverage for individuals and families. Results for 1990-1998 are based on cost for active and retired employees combined. The change in cost from 1998-2007 is based on cost for active employees only.

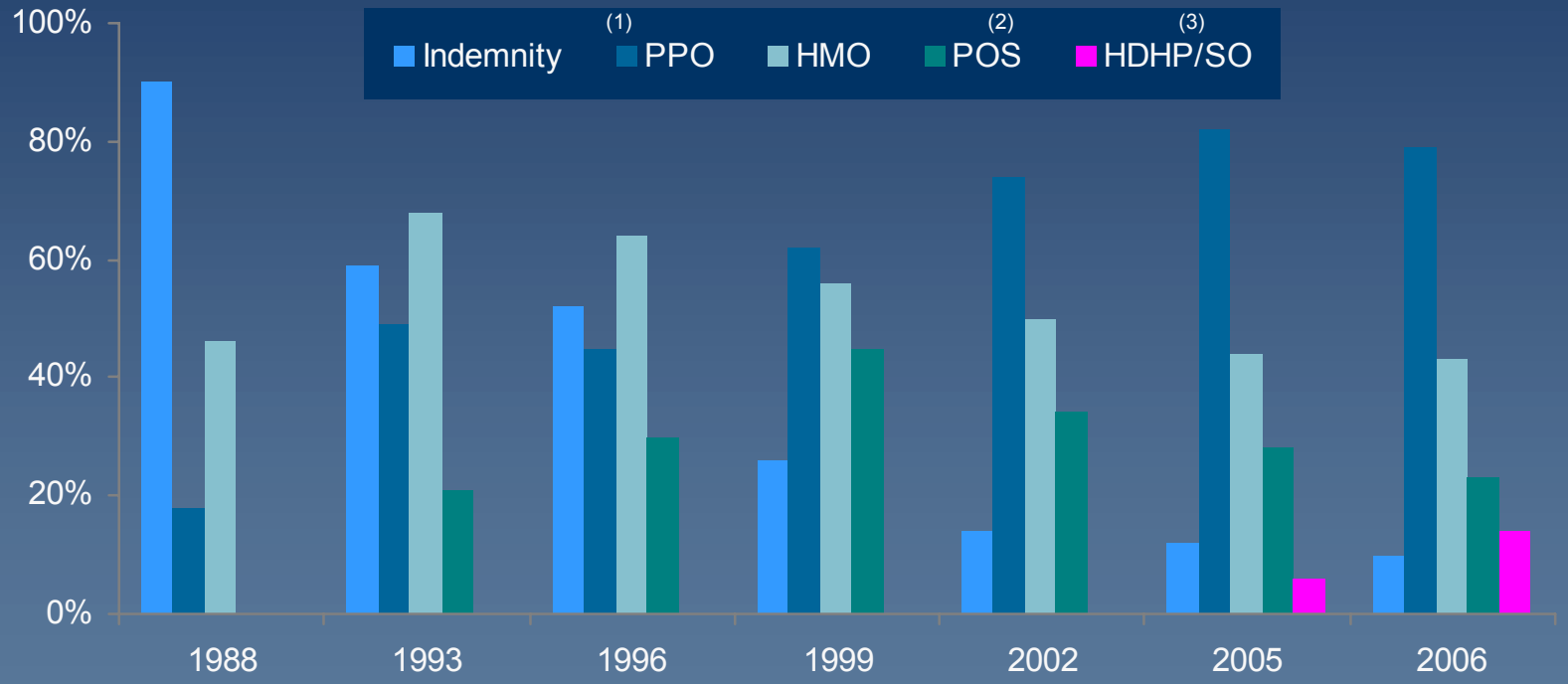
- Average increase projected for 2007 after changes to plan design
- SOURCE: MERCER HEALTH & BENEFITS -2/8/2007 Proprietary and confidential

Distribution of Employer-sponsored Health Insurance Enrollment by Type of Plan: '88-'07



Source: The Kaiser Family Foundation and Health Research and Educational Trust. Data Released 2007. *Employer Health Benefits*: 1999, 2002, 2005, and 2007.
Link: http://www.kff.org/insurance/7527/upload/7527.pdf. Slide design by Avalere Health
KPMG Survey of Employer-Sponsored Health Benefits: 1988- 1996. HDHP highlighted, **adjusted by NCSL**
(1) Conventional plans refer to traditional indemnity plans.
(2) Point-of-service plans not separately identified in 1988.
(3) In 2006, the survey began asking about HDHP/SO, **high deductible health plans** with a **savings option (HSA/HRA).**

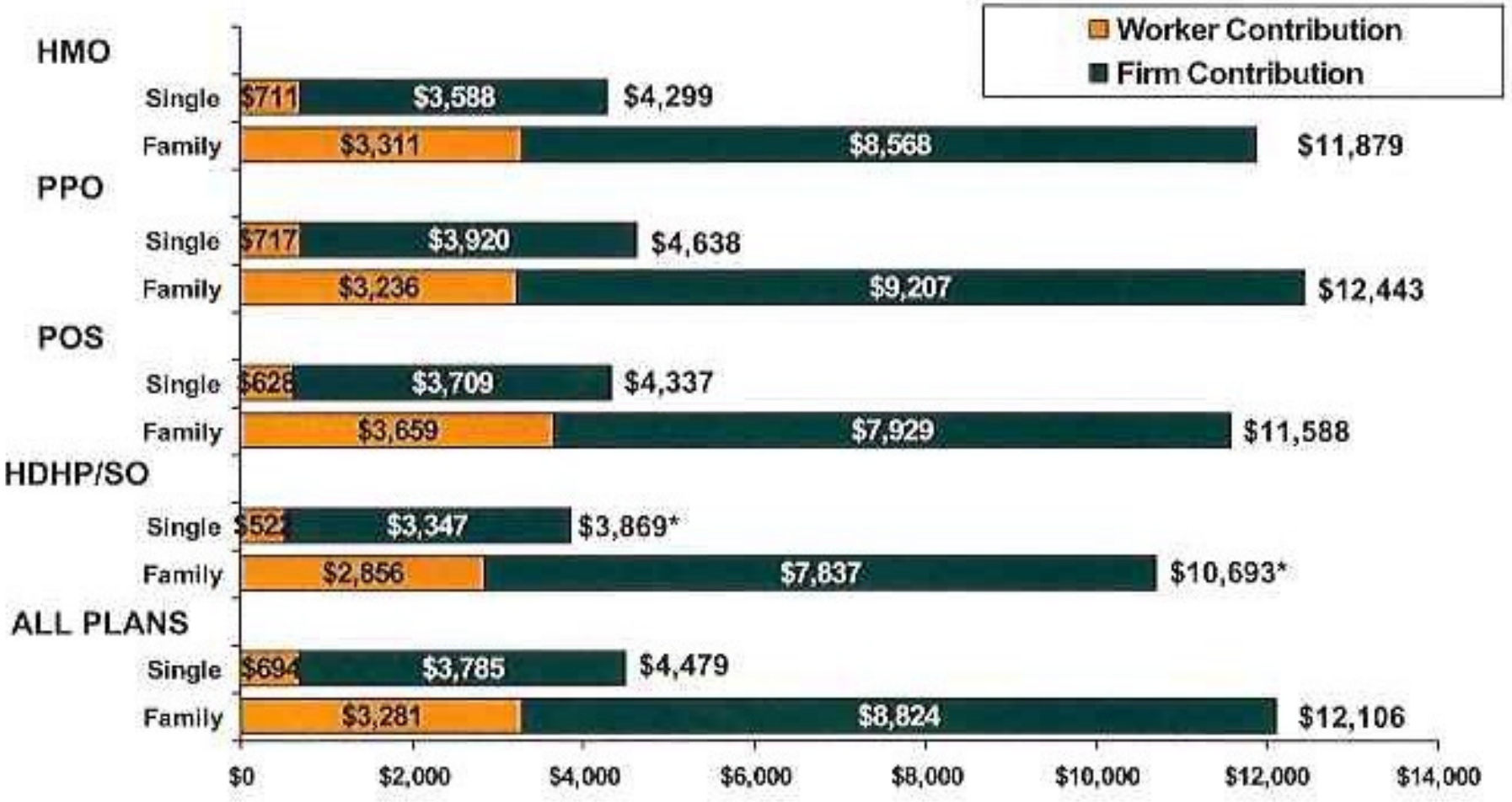
Employees with Employer-based Coverage <u>Who Can Choose</u> Types of Plans, 1988 – 2006



Source: The Kaiser Family Foundation and Health Research and Educational Trust. Data Released 2006. *Employer Health Benefits*: 1999, 2002, 2005, and 2006. Link: http://www.kff.org/insurance/7527/upload/7527.pdf.
Adopted from Avalere Health presentation, 2007/ HDHP data added by NCSL
KPMG Survey of Employer-Sponsored Health Benefits: 1988, 1993, 1996.

(1) traditional indemnity plans; also referred to as Conventional plans.
(2) Point-of-service plans not separately identified in 1988.
(3) In 2006, the survey began asking about HDHP/SO, high deductible health plans with a savings option.

Average Annual Premiums for Covered Workers, by Plan Type, 2007



* Estimate of total premium is statistically different from All Plans estimate by coverage type (p<.05).

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2007. SEPT. 11, 2007

-AND-

What Does *Affordable* Insurance Mean?

An analysis published April '07 for Massachusetts and beyond, aimed at universal coverage.

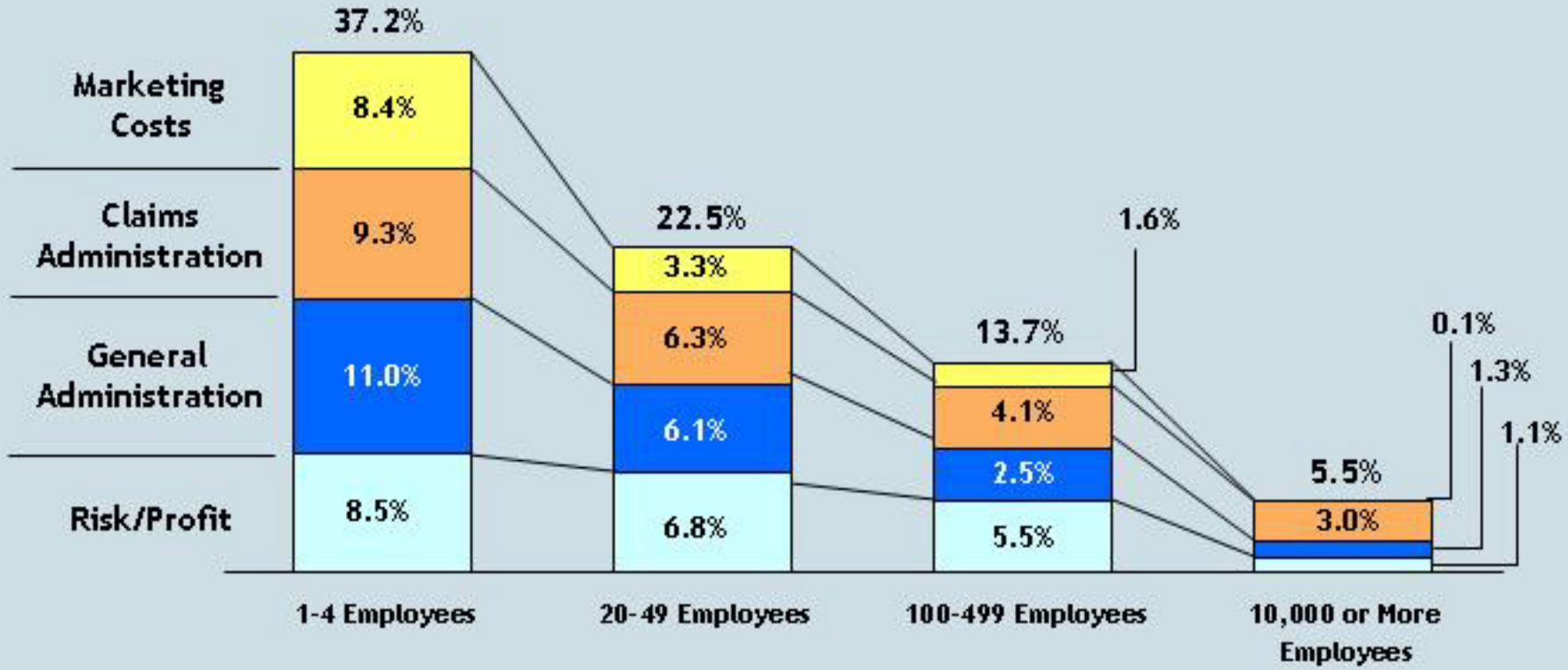
- People with low incomes can pay only small amounts toward health care.
- The "upper bound" of affordability should be set at about **8.5% of income** (for income at $61,000+/year)
- A sliding scale of affordability is needed. For people between 300% - 600% FPL, create progressive sliding scale from 4% to 8.5% of income.
- What is affordable may not be available.

Lewin model uses **7.5% of income** (Colorado example).

NCSL observation: Other economists will disagree with details, but it is important to do an in-state analysis and set standards and goals.

Insurance is More Costly to Administer for Small Groups

% of typical insurance costs



Source: Lewin presentation on "Cost and Coverage Impacts" to Colorado Commission, August 23, 2007

The Lewin Group
INGENIX

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Checklist of Use of Specific Care Management Programs

Currently offered to employees enrolled in medical plans

	Small employers	Large employers	Jumbo employers
Health website	60%	77%	87%
Health risk assessment	21%	53%	68%
Targeted behavior modification	15%	30%	45%
Nurse advice line	42%	67%	80%
Health advocate services	21%	35%	43%
Complex case management	19%	63%	82%
Catastrophic case management	22%	63%	81%
End-of-life case management	15%	40%	41%

SOURCE: **MERCER HEALTH & BENEFITS -2/8/2007** Proprietary and confidential

"Affordable Checklist" of state strategies for moderating health costs

1. Move People into Coverage Status
2. Consumer Driven Plans- Health Savings Accounts
3. Examine Insurance Mandates
4. Certificate of Need Reviews
5. Expanded use of "Cafeteria Plans"
6. New Purchasing Coalitions
7. "Value-Driven" Health Purchasing
8. Evidence-based Practices
9. Focus on Wellness and Prevention
10. Cost Transparency & Disclosure
11. Uniform Quality and Reporting Requirements
12. Reverse Poor Quality and Waste

Strategies for moderating health costs: **Move population into coverage status**

- Reduce uncompensated care costs (often high-cost emergency room services) -by moving everyone (possible) into coverage status.
- Larger risk pool = more stable, predictable (not always cheaper, unless more healthy are included)
- Covering the uninsured endorsed by insurers-AHIP, doctors-AMA, hospitals-AHA, etc.
  - *"Moderating costs is only possible if everyone is in the pool."*

    - Jon Kingsdale, Executive Director, Commonwealth Connector Authority. July 2007
- **Laura Tobler's presentation to follow**

Strategies for moderating health costs: **Consumer Driven** Health Savings Accounts (HSAs)

- HSAs allow for tax-free accumulation of savings.
  - Tax free contribution; Tax free accumulation.
  - Tax free withdrawals for health care services, COBRA and Long Term Care Ins. premiums, retiree health premiums for Medicare-eligible retirees.
- Must have qualified **"High Deductible Health Plan"**
  - Self-only: Minimum $1,100 annual deductible, $5,500 Out-of-Pocket max. (all 2007 requirements)
  - Family coverage: Minimum $2,200 deductible, $11,000 Out-of-Pocket max.
- Contributions
  - Self-only: limited to level of deductible, up to $2,850.;
  - Family: limited to level of deductible, up to $5,650 max.

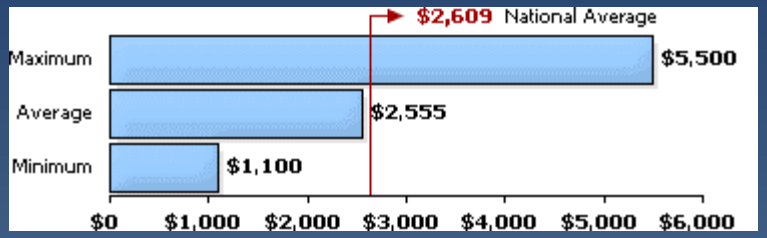
Growing enrollment and use; Premium savings: HDHP total premium about 16 to 20% lower. (ave. $640 below HMO for an individual; $1,700 for family)

Who pays high deductible portion, employer or individual, makes a big difference in the economic appeal of HSAs.

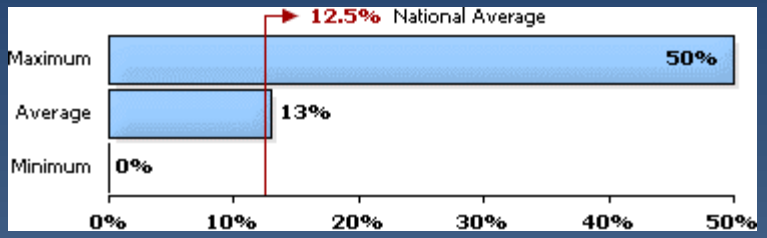
High Deductible Health Plans + HSA Plans

Iowa compared with National Averages

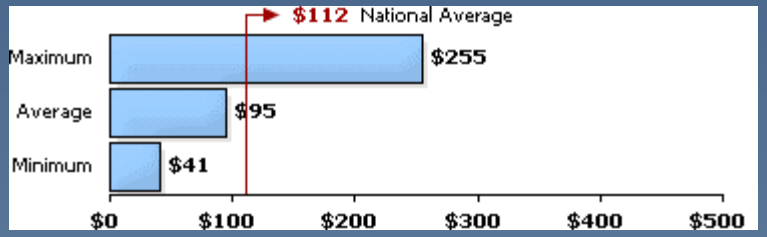
HDHP Annual deductibles



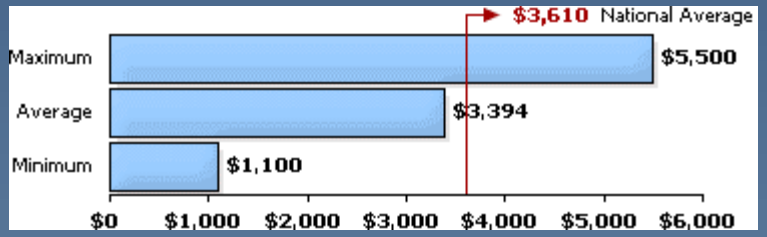
HDHP Co-Insurance



HDHP Monthly premiums, individual policy



HDHP Out-of-Pocket Maximum



Source: "Qualified High Deductible Health Plan (HDHP) Atlas VIMO comparison shopping for health" - online August 2007

Strategies for moderating health costs: #3 **Examine Insurance Mandates**

- State coverage mandates add to costs, but repeals do not assure cheaper premiums.
  - No simple answers.
  - Most existing state mandate laws are stable.
  - New mandates have virtually disappeared.
- Required mandate reviews, now in 18 states
  - MA universal law retains, freezes mandates, old & new.
  - Mandate exemptions for defined groups growing. HSAs.
- Iowa study a useful example in contrasts
  - Chiropractors add 1.49% but may save on surgery or bone specialists?
  - Diabetes self-management adds 3.63% but may be a major savings v. hospitalization.

Strategies for moderating health costs: #4 **Certificate of Need Reviews**

- Requires review of the state's need for more facilities and specialty equipment.
- "CON" laws used in 36 states including Iowa.
- Provides a structure to restrict, halt or just disclose potentially duplicative or less needed health services.
- Challenges: surgical centers, retail clinincs.
- **Iowa**: In FY 2006, 19 applications seeking $81 million; of which 14 worth $37.5 million approved.

Strategies for moderating health costs: #5 Expanded use of "**Cafeteria Plans**"

- Expand or require use of federal IRS (Section 125) "cafeteria plans" that allow full tax deduction for health premiums.
  - **Employee can save 26%**
    Employers will save 1.86% *(Mass. Calculation, 2007)*
    Employee earning $50,000 in employer's Plan has annual tax savings of $796; employer saves $161 in annual FICA taxes.
  - **RI:** stand-alone, requires all employers of 50+ workers to have a plan; no employer $$ required. (2007 law)
  - **MA** Universal plan requires "125 plans" be offered
  - **WA:** Partnership for small business employers; participants required to offer "125 plans." (2007 law)
  - **MO:** includes similar "125" requirement for employers.

Strategies for moderating health costs: #6 **New Purchasing Coalitions**

- **Early voluntary purchasing pools (1990 ~ 2000)**
  Usually based on small businesses. Not subsidized.
  Results: Limited use, not popular, costs did not drop.
- **New Purchaser Coalitions:**
- groups of public and private purchasers working together to standardize demands on suppliers and share value-driven strategies.
- reaching agreement among purchasers with different priorities can be challenging, but
- coalitions can leverage greater market share and wield more influence with suppliers.
  Minnesota Smart Buy Alliance = 60% of state residents.
  Washington's Puget Sound = 1 million+ lives; 140 org's.

- **Connectors & Partnerships:** Pooled negotiation and marketing. *See Laura Tobler's presentation. MA & WA laws*

Strategies for quality & moderating health costs: #7 **"Value-Driven Health Purchasing"**

- Recent state public/private partnerships have built into their purchasing contracts
  - evidence-based medicine,
  - new information technology and e-records; good data collection,
  - tiered premiums,
  - pay-for-performance incentives & measures,
  - Designating high-performance providers as "centers of excellence"
- Minnesota - Smart Buy Alliance
  Washington -Puget Sound Health Alliance,
  a broad group of public and private health care purchasers, providers, payers (health plans), and consumers, working to develop public performance reports on health care providers and evidence-based clinical guidelines.

"Value-Driven Health Purchasing" Example:
Minnesota Smart Buy Alliance

- Created Nov. 2004 - evolved from earlier efforts
  - Large self-insured employers (BHCAG)
- Includes state agencies (Human Services with Medicaid, SCHIP, public employees), coalitions of businesses and labor unions.
- Represents 60 percent of residents = 3 million.
- Using common quality standards; pay-for-performance.
- One early financial "payoff":
  - State employees had 0% premium increase in 2006; those who pay the premiums got a 4.4% reduction

See: "Case Study of MN" by Commonwealth Fund, August 2007

Strategies for quality & moderating health costs: **Evidence-based Practice** (A)

- Ideally use objective science to link quality and cost effectiveness
- Public, academic and private sector efforts.
- Initiative and federal funding within HHS:
  - Agency for Healthcare Research and Quality (AHRQ)
  - Sponsors 13 "Evidence-Based Practice Centers (EPCs)
  - "EPCs review all relevant scientific literature on clinical, behavioral, and organization and financing topics to produce evidence reports and technology assessments."
  - The resulting evidence reports and technology assessments are used by Federal and State agencies, providers, payers, others.
  - Reports accessible: www.ahrq.gov/clinic/epcindex.htm

Strategies for quality & moderating health costs: **Evidence-based Practice** (B)

Drug Effectiveness Review Project (DERP)

- 13 states, "joined together to provide systematic evidence-based reviews of the comparative effectiveness and safety of drugs in many widely used drug classes."
- Based in Oregon; initiated by former Gov. Kitzhaber
- Reports are public; anyone may use them.
- Not tied to "rationing;" not binding on any agency.
- may facilitate understanding of generics and brand name Rx.

- DISPUTES ABOUT APPROACH:

  "DERP decision to ignore cost-effectiveness considerations reveals a society still unable to consider economic factors openly in evidence reviews.
  -Neumann, Health Affairs June 2006
  Rx manufacturers disagree with some results.

Strategies for quality & moderating health costs: #9 **Focus on Wellness & Prevention**

- An estimated $300~$600 billion of health spending goes to treatment of disease and injury that might have been preventable.
  - Traditional insurance focused on treatment, plus a few low cost screenings for early detection.
  - Now, a growing trend toward voluntary, educational campaigns for wellness, exercise, healthy diet.
- State reforms can be a vehicle for new features:
  - Direct financial incentives for weight loss, non-smoking, BMI improvement; early treatment of preventable diseases.
  - Indiana-Personal Wellness Responsibility Account, $1,100 HSA.
  - Rhode Island created a "wellness health benefit plan."
  - Other state examples: AR, AZ, DE, HI, KS, OK, ND, OH, TX, VT
  - NCSL Wellness page www.ncsl.org/programs/health/WellnessOverview.htm

Strategies for quality & moderating health costs: #10 **Cost Transparency & Disclosure**

Cost, price and quality information is deemed a critical component of Value Based Purchasing and consumer-driven approaches. The initiatives involved collecting data from providers and health plans, and applying quality, efficiency, and "value" measures (a combination of quality and cost) to present comparative information.

- **Transparency and Public Reporting.** At least 12 states have enacted price disclosure laws and have state web material:
- **California, Florida and Maryland** have state-run consumer web sites on hospitals' charges and readmission rates.

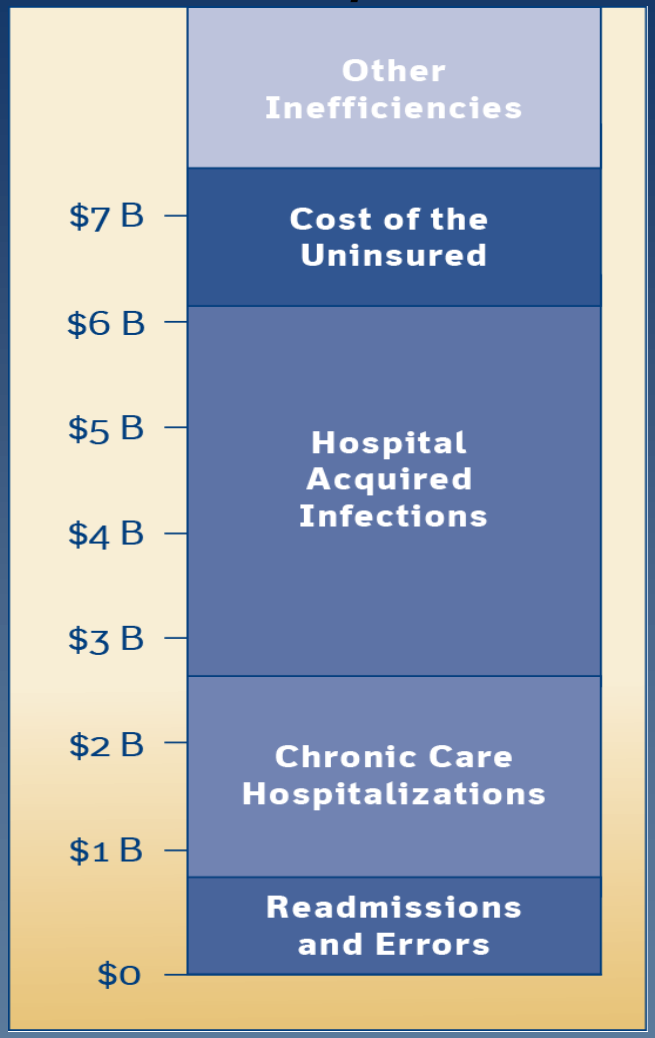
- Purchasing coalitions are working to build more universal repositories of data that would be available to and used by the wider public and all employer/purchasers. Used in **WA, WI, MA**.

11 Uniform Quality Measures and Reporting Requirements

- This strategy involves multiple purchasers joining together to establish uniform quality measures, which are translated into standard data requirements for health plans or providers.
- The intent is to:
  - reduce the burden on suppliers of varied reporting requirements from purchasers (thereby enhancing cooperation);
  - reduce confusion to employers and consumers when purchasing health care;
  - and allow providers to focus on improving quality measures that reflect evidence-based medicine.
- State Employee Benefit plans in MA, WA, WI are in the lead on these policies.

Source: Value-Driven Health Care Purchasing: Four States that Are Ahead of the Curve, Commonwealth Fund, 8/15/07.
http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=515778

Use savings from current waste & inefficiency *Pennsylvania example:* A Cost analysis -



Source: **"Prescription for Pennsylvania" (2007)** Governor Edward G. Rendell, State of the State, January 17, 2007

http://www.gohcr.state.pa.us/prescription-for-pennsylvania/Rx-for-Pennsylvania-Presentation.pdf

Make Small Business Insurance More Affordable: **Insure Montana:**

- Small Business Health Care Affordability Act
  - 1) For small businesses with 2-9 employees that are currently providing health insurance , they are eligible for refundable tax credits.
  - 2) For businesses previously unable to afford health insurance for their employees, provides health insurance coverage through a small business purchasing pool.
  - Pool insurance is subsidized on a sliding scale basis.
  - Over 1,550 small businesses are enrolled as of August 2007; there is now a waiting list due to funding constraints.
  - **Funding**: by a **new tobacco tax.**

- Other states working on this goal with different plans: NY, WV, TN, NM, OK [June '07 law] , AR, AZ.
  Visit http://www.ncsl.org/programs/health/business.htm

Small Business: Healthy Indiana Plan"

- A 50% small business wellness program tax credit aimed at 103,000 businesses employing 815,000 workers.
- Requires insurance companies to allow parents to keep children on a family insurance plan up to the age of 24.
- Allows companies to use pre-tax dollars to pay for employee health insurance coverage. Part of the program also includes both a federal and state income tax deduction for employees.
- Expected to help 132,000 Hoosiers earning up to 200 percent of the poverty level.
- Expansion of the state's children's health insurance program to cover up to 39,000 additional needy children.
- Increased eligibility for pregnant women on Medicaid, estimated 17,000.
- **Funding:** **cigarette tax increase** per pack to fund various health related expenses. The law will increase cigarette tax collections by an estimated $187.2 M in FY 2008 and $206.5 M in FY 2009.
- - signed into law by Gov. Daniels May 10, '07

Cover Tennessee

- A market based public/private partnership plan for small employers and uninsured workers with incomes below 250 percent of FPL. ($25.5k /yr for 1; $51.6k for family of 4)

- Cover Tennessee is guaranteed access to basic, major medical coverage for $150 a month with the cost shared equally by the individual, employer, and state government.

- **Funding:** Tennessee tripled its tax on cigarettes to produce $239 million in new revenue for FY 2008.
- Cover Tennessee is not an entitlement — "it is voluntary health insurance coverage, affordable to participants and to the state."

The Role of Building Consensus: *Example:* **Colorado's Commission**, 2006-07

- Bipartisan 27-member Blue Ribbon Commission, convened by Legislature and Republican Governor, continued by Democratic Governor.
- Issued a public "RFP" seeking reform plans - received 31 proposals in May; narrowed to four in June. Lewin analysis.
- Will issue a report this fall to the '08 legislature.

Better Health Care for Colorado Medicaid-funded insurance subsidies under 300% FPL Basic benefit package through large pool with annual benefit cap; individuals can use subsidy to purchase employer-sponsored insurance Medicaid reform, including managed care, P4P, consumer-directed home care	**Solutions for a Healthy Colorado** Individual mandate-all must have insurance. Guaranteed issue of a core benefit plan for individual insurance; modified community rating Subsidies for those up to 250% FPL
A Plan for Covering Coloradans Individual mandate- must have insurance or pay assessment if they do not "Pay or play" for employers- either contribute to employee coverage or pay assessment Purchasers pool to negotiate with providers; Subsidies up to 400% FPL and small businesses.	**Colorado Health Services Program** Single-payer program governed and administered like a public utility Premiums charged through income tax or payroll deductions Consumers may choose any licensed health care provider in the state

The Role of Accurate Data: Using a sound simulation model

Good, current health data is critical, but hard to find and compare.

Effective examples: 1) David Lind Associates- today

2) The Lewin Group estimates using the Health Benefits Simulation Model.

Provide precise FY 2007-08 estimated figures.

Examples provided by Lewin Group

John Sheils & Mark Zezza for the CO Blue Ribbon Commission

- Colorado 2006 population estimate is 4,753,377.
- Iowa 2006 population estimate is 2,982,085 (62.7% the size of CO)

Projected In-state Spending by Type of Service: FY 2007-2008 (in millions) *[Colorado example]*

Type of Service	CY 2000	Average Annual Growth Rate 2000-2004	CY 2004	Projected Average Annual Growth Rate 2004-2007	Provider Estimate FY07-08	Resident Estimate FY07-08
Hospital	$5,598	9.1%	$7,926	8.1%	$10,426	$10,438
Physician	$4,719	8.7%	$6,599	6.9%	$8,343	$8,563
Dental	$1,168	7.8%	$1,577	7.2%	$2,013	$2,065
Other Professional	$738	7.0%	$967	6.6%	$1,208	$1,240
Home Health	$305	4.6%	$365	5.6%	$442	$435
Prescription Drugs	$1,335	8.4%	$1,846	4.6%	$2,163	$2,163
Medical Durables	$372	4.8%	$449	4.6%	$526	$540
Nursing Home	$938	6.2%	$1,192	6.1%	$1,464	$1,434
Other Personal Care	$538	13.3%	$885	10.5%	$1,254	$1,254
Total	$15,711	8.5%	$21,806	7.1%	$27,838	$28,130

Source: Lewin Estimates using data from Centers for Medicare & Medicaid Services. For CO Task Force, 6/07

Latest headlines:

How existing spending may affect future reform

– NY Times, Sep 18, 2007, using CMS Office of the Actuary data from 2004

States Differ Widely in Spending On Health Care, Study Finds

By ROBERT PEAR

WASHINGTON, Sept. 17 — A new federal study shows huge variations in personal health spending among states, ranging from an average of nearly $6,700 a person in Massachusetts to less than $4,000 in Utah.

The study, published on Monday in the Web edition of the journal Health Affairs, said that Massachusetts had the highest per capita spending on hospital care than any other state, while Maine spends more than other states on home and community-based care. Maine had the second highest level of spending on doctors' services, after Alaska.

Utah had the lowest per capita spending on doctors and hospitals.

Sara Rosenbaum, a professor

- Iowa falls just above average in personal spending per capita.

IA $5,380 /yr | US $5,283

Average annual growth:

IA 6.3% | US 6.3%

Medicaid annual growth:

IA 6.2% | US 3.4%

IA uses more heath care than it produces (105.4%)

"The variations help explain why some states can achieve health care reform on their own, without a huge infusion of federal money, while others cannot." – *Sara Rosenbaum, GWU*

"States that spend more per capita often have a lower quality of care." – *Karen Davis, Commonwealth Fund*

In Summary…. Key cost themes

- Cost solutions paired with coverage expansion. (within most passed 2006-07 laws)
- Premium affordability is a core feature or goal in most state activity this year.
- Public-private partnerships embraced by most.
- Role and impact within small business.
- "Political" successes most common after all stakeholders are at the table; bi-partisan endorsers.
- "Economic" successes can be measured in different ways - still fairly early to judge.

Massachusetts: Signing of the Health Reform Law, 2006

NCSL Resources

- Richard Cauchi, Program Director, Health-Denver
  303 856-1367 dick.cauchi@ncsl.org

- WEB: Insurance -
  www.ncsl.org/programs/health/healthmc.htm
- Health Finance -
  www.ncsl.org/programs/health/finance.htm
- Critical Health Areas Project -
  http://www.ncsl.org/programs/health/forum/chap/index.htm